Maternal Child Health Program

PLANNING & IMPLEMENTATION GUIDELINES

Contents

Introduction

1. MCH Program Vision, Goals, Objectives and Outcomes
    1.1 The Vision
    1.2 Short-term Goal
    1.3 Long-term Goal

2. MCH Program Description
    2.1 MCH Program Philosophy
    2.2 Definition of MCH
    2.3 Why Develop Programs for MCH?
    2.4 The Need: The Health Status of Pregnant First Nations Women, Infants and Young Children
    2.5 Effectiveness of MCH Program Components

3. Organizational Structure, Role and Responsibilities
    3.1 Federal Government
    3.2 FNIHB Regional Offices
    3.3 Community

4. Program Activities
    4.1 MCH Program Interventions
    4.2 Overview of Components of the MCH Program on Reserve
    4.3 Activities of CHNs and FVs During Home Visits

5. Program Planning and Implementation
    5.1 Phased-in Approach to MCH Program Implementation
    5.2 Description of FNIHB Roles and Responsibilities in Planning
    5.3 Regional Roles and Responsibilities in Planning
    5.4 Building Community Plans

6. Program Evaluation Framework

Annex A: Inequities of Health Status for First Nations Women and Young Children

Annex B: Health Canada's Community-based Programs

Annex C: Screening Strategies Recommended During Pregnancy

INTRODUCTION

Supporting parents through pregnancy, birth and child rearing is crucial in promoting the optimal health and development of infants and young children. The Maternal Child Health (MCH) Program provides these supports to First Nations families living on reserve through preconception, pregnancy, infancy and early childhood. These program guidelines describe the program components and provide a framework for program planning, implementation and evaluation. These guidelines are flexible, so communities can build on what is already working within the community to ensure that the MCH Program meets their unique needs. Community workers will also want to refer to the MCH Workplan Template for further information.

1. MCH PROGRAM VISION, GOALS, OBJECTIVES AND OUTCOMES

1.1 The Vision

The vision of the MCH Program is that all pregnant First Nations women and families with infants and young children who live on reserve will be supported to reach their fullest developmental and lifetime potential. The vision will be achieved by providing access to a local, integrated and effective MCH care system that responds to individual, family and community needs.

1.2 Short-term Goal

The short-term goal is to develop a program of MCH services in consultation with Aboriginal organizations and communities, provinces/territories and other key stakeholders. These programs will be designed to improve health and social outcomes for pregnant women and families with infants and young children in identified First Nations communities across Canada .

1.2a Short-term Objectives and Expected Outcomes

Objective	Outcomes
1. To implement an accessible, comprehensive and coordinated approach to MCH services in communities.	▸ New partnerships developed in the community, and with other health systems ▸ Improved access to service coordination and specialized services for families and children with complex needs ▸ Increased involvement by Elders in supporting pregnant women and families with young children
2. To ensure that all families have access to MCH services, including home visiting and service coordination.	▸ Increased access to supports for pregnant women and families from preconception through pregnancy, birth and parenting

3. To address the risk factors affecting the health of pregnant mothers and families with infants and children.	▸ Pregnant women and parents of children from birth to six years linked to the MCH Program ▸ Increased early identification of families at risk of poor outcomes ▸ Families linked with risk reduction interventions targeting tobacco, alcohol and drug use, improved nutrition and increased physical activity ▸ Increased participation of fathers in parenting programs ▸ Increased access to social supports ▸ Increased opportunities for children with special needs to participate in their community ▸ Strengthened parenting skills within a nurturing environment ▸ Increased breastfeeding initiation and duration ▸ Improved identification and support for mothers with postpartum depression ▸ Improved oral health practices in parents, infants and children ▸ Increased childhood immunization rates
4. To increase First Nations-specific training of MCH providers to facilitate culturally competent, culturally safe care[1].	▸ Provision of First Nations-specific training materials and resources to support staff who deliver MCH services ▸ Provision of cultural competence training for health care providers to raise awareness of cultural beliefs, values and practices around pregnancy, birth and parenting ▸ Increased provision of culturally safe care
5. To develop an evaluation strategy and tools to measure achievement of the program goals and objectives.	▸ Use of evaluation tools to measure the effectiveness of the program and the achievement of program goals and objectives ▸ Provision of key lessons learned from the evaluation to other communities so they can develop MCH programs
6. To build on the development of policy frameworks to build on investments in MCH.	▸ Use (by FNIHB) of short-term evaluation data to seek out funding enhancements to support MCH as a core public health program in every community.

1.3 Long-term Goal

The long-term goal for the MCH Program is to improve health and social outcomes for pregnant First Nations women and families with infants and young children so that they all reach their full developmental and lifetime potential.

[1] *Cultural safety* is the effective nursing or midwifery care of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. (Nursing Council of New Zealand (March 2002) "Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery Education and Practice", Wellington NZ: Nurses Council of New Zealand p8.)

1.3a Long-term Objectives and Expected Outcomes

Objectives	Outcomes
1. To improve health outcomes for pregnant women and families with infants and young children in First Nations communities	▸ Reduced prevalence of prenatal risk factors ▸ Improved birth outcomes ▸ Lower infant mortality from causes such as SIDS ▸ More infants and young children meeting physical, emotional, social and cognitive developmental milestones ▸ Lower rates of respiratory infections and otitis media in young children ▸ Decreased incidence of injury and death for children under six years from unintentional accidents ▸ Decreased incidence of family violence ▸ Lower rates of dental decay in young children
2. To reduce inequities of access to MCH services, ensuring that MCH services on reserve are consistent with the standard of care provided by the provinces and territories for other pregnant Canadian women and their families	▸ More young adults having access to preconception information ▸ More pregnant women and families receiving an acceptable standard of prenatal, postpartum and well-baby primary health care ▸ More families receiving service coordination to increase their access to targeted services, as well as other services for families living with complex issues ▸ More families that are satisfied with the quality, range and accessibility of services available in their community ▸ More communities with the capacity to provide an MCH Program
3. To develop a comprehensive, coordinated approach to MCH services to build on the foundation of current investments	▸ A coordinated MCH service delivery system on reserve that builds on the strengths of the community and is grounded in First Nations culture
4. To identify opportunities to bring safe birthing options closer to First Nations communities in collaboration with existing service providers, traditional midwives and tertiary care providers	▸ Ways to bring more safe birthing options to First Nations communities ▸ Planning processes to explore options to bring safe birthing closer to communities ▸ A parallel process being developed on midwifery to help address this objective

5. To identify and address the gaps in programs and services for families with young children, particularly those with special needs	▸ Reduced levels of stress for families caring for a child with special needs ▸ More access to service coordination for families and children with special needs ▸ Improved availability and/or access to community-based services for children with special needs ▸ More participation in their community by children with special needs ▸ A parallel process being developed on special needs to help address this objective
6. To develop and put an ongoing evaluation framework in place to measure the long-term impact of the MCH Program and demonstrate achievement of long-term objectives	▸ Short-term evaluation tools modified to measure long-term impacts ▸ More community participation in program evaluation and health monitoring through training and support ▸ Outcomes that show effectiveness of the program to achieve long-term goals and that highlight the need to support MCH as a core public health program in every community

2. MCH PROGRAM DESCRIPTION

2.1 MCH Program Philosophy

The period from conception to six years of age has the most influence of any time period on brain development, behaviour and health. The effects of maternal health during pregnancy and of childhood experiences on brain development during the first six years last a lifetime. Preconception information provided to young adults helps to ensure a healthy start to pregnancy.

2.2 Definition of MCH

MCH includes all aspects of maternal, child and family health such as:

- basic human needs
- wellness
- social well-being (including secure, non-violent relationships)
- community supports
- cultural identity/tradition

MCH programs focus on mind, body and spirit. They also build on the strengths and capacities of pregnant women and families with infants and young children within the context of their community.

The principles underlying MCH Program planning and implementation include:

- community based/community paced
- grounded in culture, values and language
- built on community strengths
- coordinated with existing programs and service providers

The MCH Program is built on principles of health promotion and disease/injury prevention, early intervention, and integration/coordination of services. Each component of the program is evidence-based and has shown effectiveness in improving health outcomes. MCH Program components are available to all pregnant women and families. Service coordination and long-term home visiting will be extended to families living with complex issues and/or children who have special needs.

Definition of Principles Underlying Planning and Implementation	
Community based/community paced	▸ Communities will develop their own approach to MCH services within the guidelines of the program. Communities will build the infrastructure, capacity and partnerships needed to support the program within realistic, achievable time frames.
Grounded in First Nations culture, values and language	▸ MCH interventions that include culture, values and language have a greater impact on health and social outcomes. Cultural practices promote infant/child health and are crucial to families' adaptation throughout their child-bearing years. Involvement of Elders is a fundamental part of the program.
Built on community strengths	▸ The MCH Program is built on the strengths of each community, including natural maternal leaders, and draws on the rich traditional resources available in all communities.
Coordinated with existing programs and service providers	▸ The MCH program cannot function in isolation. One measure of its effectiveness will be the degree of coordination achieved with the programs and services that are already provided in the community, for example, Nursing, Aboriginal Head Start on Reserve (AHSOR), Fetal Alcohol Spectrum Disorder (FASD), Brighter Futures Initiative (BFI), Canada Prenatal Nutrition Program (CPNP), Home and Community Care (H&CC), Building Healthy Communities (BHC), Children's Oral Health Initiative (COHI), First Nations and Inuit Tobacco Control Strategy (FNITCS), National Native Alcohol and Drug Abuse Program (NNADAP), etc.
Definition of Principles Underlying the MCH Program Components	
Health promotion and disease/injury prevention	• Promote healthy pregnancy and healthy growth and development of infants and young children to prevent poor health/injury. • Ensure that all children have the opportunity to reach their full potential.

Early intervention	▸ Screen and assess families from pregnancy to school entry to identify expectant mothers, infants and children at risk for poor health outcomes. ▸ Provide the support, education and resources needed to children and their families to achieve healthy birth outcomes and healthy growth and development.
Coordination	▸ Embed MCH in the community and coordinate it with existing programs and services. ▸ Provide access to coordinated services for all families.
Evidence based	▸ The effectiveness of MCH programs (home visiting, coordination of services, service integration) have been demonstrated through national and international research.
Broad based with additional supports for families living with complex issues and/or children who have special needs	▸ Provide services for all pregnant women and families based on their broad-based needs. ▸ Coordinate services to help increase access for families living with complex issues, including special needs services. These services include infant development, speech and language, audiology, vision screening and children's mental health.

2.3 Why Develop Programs for MCH?

Preconception

Preconception information for young adults focussing on reproductive health and healthy relationships can help young adults make responsible choices around family planning. This information also helps parents to enter into a pregnancy and the early childhood years in good health.

During Pregnancy

A healthy pregnancy increases the likelihood of a healthy infant. Because the brain develops during pregnancy, it is influenced by the health behaviours of expectant women and their partners. Not smoking, not drinking alcohol and using other drugs and ensuring good nutrition and physical activity during pregnancy reduces the risk of preterm births, low birthweight and other health complications.

In the First Year

The birth rate for First Nations mothers is double that in the rest of Canada. This high rate fuels the need for adequate and accessible services that meet the social and health needs of pregnant women and families with infants and children. Many risk factors in infancy and the first year of life can be reduced. For example, breastfeeding provides essential nutrition and important stimulation for newborns and infants. Breastfeeding enhances infant health by reducing susceptibility to developing respiratory infections, otitis media, and allergies and asthma. Infant stimulation from parents and other caregivers is also key to healthy development.

Secure relationships with parents or caregivers and opportunities for stimulation and learning can have a positive influence on the brain's ability to think, regulate body functions and respond to stresses experienced later in life. Some maternal health problems after birth, such as postpartum depression, can reduce a mother's responsiveness to her infant and her ability to provide adequate infant care. Postpartum depression rates range from 10% to 25% for new mothers.

Parenting Young Children

Early childhood is a critical and vulnerable time when risk factors like parenting difficulties and limited opportunities for stimulation and social interaction have lasting effects. A safe environment at home, in the car and in the community can prevent injuries. A smoke-free home will lower the risk of otitis media and respiratory infections. Proper nutrition for infants and young children is important for healthy growth and development because vitamin deficiencies and poor nutrition can have negative and often irreversible effects.

2.4 The Need: The Health Status of Pregnant First Nations Women, Infants and Young Children

On average, First Nations pregnant women and families with infants and young children have poorer health than the general Canadian population. See Annex A for examples of inequities of health status for First Nations women and young children.

Factors that may contribute to reduced capacity to parent and poor MCH include:

- history of residential school experience
- lack of prenatal care
- family violence, neglect and abuse
- negative experience with the child welfare system
- environmental exposure to substances such as alcohol and tobacco
- parents affected by FASD
- high teen birth rate
- social/economic factors including poverty, under housing, unemployment
- higher rates of single-parent families
- lack of social support
- high levels of perceived stress

The effects of these factors can be lessened by an MCH Program that provides support, education and service coordination for families during pregnancy, after birth and during the first years of the child's life. Because of the research that demonstrates that they work, MCH programs are provided in all provinces and territories across Canada. Services usually include access to reproductive health programs, prenatal supports, in-home visiting and assessment, identification of parents/families at risk and referrals to other services. All provinces and territories also currently provide more intensive or targeted services for children and families at risk. These services include:

- intensive home visits

- infant development programming
- developmental supports in preschool settings
- early language programs
- rehabilitation services

These services are not usually available to First Nations families that live on reserve.

2.5 Effectiveness of the MCH Program Components

Home Visiting Programs

Home visiting by Community Health Nurses (CHNs) and Family Visitors (FVs) benefits the health of mothers, infants, children and families. Home visiting can improve:

- reproductive health and physical growth,
- maternal employment
- nutrition
- health habits and lifestyle
- parenting
- realistic expectations of children
- parent–child interaction
- access to social support
- knowledge
- use of services

Home visiting can reduce mothers' anxiety, depression and tobacco use, child abuse and neglect. It can also reduce the need for more costly treatment services. Home visiting to clients who have increased risk factors is associated with better health and social outcomes. The effectiveness of home visiting depends on successful coordination with other broad strategies and programs in the community to ensure comprehensive access to health services.

Integrating Culture into Care

The prevention components of MCH care can be enhanced for child-bearing families by moving beyond medically based prenatal and postpartum services to integrate cultural values, customs and beliefs into all program components.

Screening and Assessment

All pregnant woman and families with infants and young children in the community will have access to the services provided through the MCH Program. Screening and assessment is an effective way for nurses to identify the needs of families and to determine the level and types of services that will benefit them most.

Asset Mapping

During the planning phase, it will be important for communities to identify local strengths, programs and services that may impact the MCH program. This step provides a foundation for putting the program in place and can address identified needs in the community. The process of

identifying strengths will also show the gaps, weaknesses and barriers that should be addressed through community planning. Asset mapping is one way of identifying theses strengths and service gaps within a community.

Service Coordination or Case Management
At an individual level, providing programs and services for families in a coordinated way can improve follow-through with referrals, overcome barriers to access, increase satisfaction with the level and quality of care received, and enhance health and well-being.

Health Promotion
Health promotion strategies can improve MCH in communities in many ways. Health promotion interventions include promotion of physical activity and healthy nutrition, substance abuse prevention, preconception health counselling and injury prevention. The MCH Program should be linked to other public health initiatives that focus on health promotion, such as AHSOR, BFI, BHC, CPNP, COHI, FASD, FNITCS, NNADAP and nursing services, etc., so that families benefit from a variety of approaches.

3. ORGANIZATIONAL STRUCTURE, ROLES AND RESPONSIBILITIES

3.1 Federal Government
In September 2004, First Ministers and the Leaders of the Assembly of First Nations (AFN), the Inuit Tapiriit Kanatami (ITK), the Métis National Council (MNC), the Congress of Aboriginal Peoples (CAP) and the Native Women's Association of Canada (NWAC) reached an agreement to work together to develop a blueprint to improve the health status of Aboriginal peoples and health services in Canada. In support of this commitment, the Government of Canada announced new investments of $700 million over five years for Aboriginal health initiatives. The Budget in February 2005 confirmed these investments by announcing $145 million for maternal and child health, including $35 million for enhancements in early childhood development (ECD).

Overall, the federal vision for First Nations health is for a sustainable, effective, integrated system that reduces the gap in health status between First Nations and other Canadians, and provides quality services in an integrated, coordinated and equitable way. An increased role and capacity in governance and planning of health services among First Nations communities is a priority.

At the national level, FNIHB will work with the AFN on:

- MCH Program guidelines and logic model;
- communication strategy and materials;
- an evaluation framework;
- identifying core competencies of new FNIHB staff positions and providing guidelines for competencies for community-based staff;
- work plan templates;
- screening and assessment tools;

- developing training materials;
- creating an inventory of educational resources and materials;
- supporting the development of First Nations parent teaching resources;
- funding mechanisms;
- program expansion opportunities; and
- fostering collaboration and coordination at the national level among community-based programs.

Aboriginal Midwifery Education Program
Training for Aboriginal midwives provides culturally appropriate maternal/newborn and obstetric services. As part of a primary care team, trained midwives will bring birthing services primarily to women living in remote and northern Aboriginal communities. The availability of accredited midwives in Aboriginal communities will help to ensure that both mother and baby have access to maternal/newborn care where they live. Support for this program also takes place at the national level.

See Annex B for a description of Health Canada's community-based programs.

3.2 FNIHB's Regional Offices
In consultation with communities, the Regional FNIHB Office is responsible for overseeing the planning, implementation and evaluation of the community-based MCH Programs within their Region. Additional MCH Program staff will be hired to lead the planning, implementation and evaluation regionally. They will also provide mentoring and effective support to the communities that are implementing MCH services or working toward increasing capacity so they can submit MCH work plans in subsequent program years.

Overview of the role of the Regional FNIHB Office:

- facilitate regional communication;
- support regional MCH planning committees/workgroups;
- work with regional planning processes to identify communities to participate in the MCH Program in years 1 and 2;
- identify and address implementation needs;
- develop a comprehensive regional work plan;
- work closely with communities to complete multi-year work plans;
- fund multi-year work plans based on the planning phase of the community;
- support regional training of program staff;
- work with other interested communities to increase readiness/capacity to provide the MCH program in subsequent years; and
- support participation in evaluation activities.

3.3 First Nations Community
Communities will work independently or collectively to develop, implement and evaluate multi-year MCH work plans in consultation with the Regional FNIHB Office. Community leaders will

play a key role in the program planning process by providing their support for MCH as a community priority. Community leaders will also be key to establishing links with programs and services provided off reserve to facilitate cooperative planning. Communities will use existing planning mechanisms or establish a new community planning committee to support the MCH program. These planning mechanisms will involve key stakeholders such as community leaders; health directors; nurses; other health care providers; traditional healers; midwives; child welfare workers; BFI, BHC, CPNP, FASD, H&CC, NNADAP and AHSOR program staff, as well as volunteers and other community members as appropriate.

4. PROGRAM ACTIVITIES

4.1 MCH Program Interventions

The MCH Program emphasizes health promotion strategies, early identification of risk factors that may affect children's development and/or family health, and early intervention while acknowledging the importance of treatment of health problems and crisis intervention.

The 2005 *Report on Maternal Child Health in Canada* recommends key screening and intervention strategies to improve the overall health and well-being of all mothers, infants and children. The MCH Program on reserve provides broad-based community supports for all families that are consistent with these strategies, as well as services for children with special needs.

The interventions recommended in the above report to promote the best health possible during pregnancy, postpartum and throughout early childhood include:

- smoking cessation programs before and during pregnancy;
- screening and counselling women who drink alcohol during pregnancy; and
- access to and use of vitamin supplements containing folic acid before and during the first trimester of pregnancy.

The interventions recommended to promote the best health possible from birth to age six include:

- promotion of the benefits of breastfeeding and support for women who choose to breastfeed;
- education of parents and caregivers on proper infant sleep positions and ways to reduce the risk of SIDS;
- provision of childhood immunizations; and
- education and counselling for parents on injury prevention and promotion of infant/child safety (including safety devices and car seat restraints).

The promotion of healthy growth and development, positive parent–child interactions and secure infant–parent relationships have also been identified as key interventions in several other reports on child health.

Screening strategies that the report recommended during pregnancy and from birth to age six are described in Annex C.

4.2 Overview of Components of the MCH Program on Reserve

A) Individual/Family Focussed Components

1. Screening and assessment (during pregnancy, at birth, and anytime during a child's development from birth to age six)

2. Home visiting (by CHNs and FVs) to all families, as needed

3. Service coordination to increase access to services for families living with complex issues and/or with children who have special needs

B) System-level components

In addition to components that provide direct support to families, the MCH Program has system-level components. These include:

1. The development of a shared local vision for the health and well-being of children within each community

2. Coordination of services to facilitate the provision of accessible services that are efficient and effective

A) MCH Individual/Family Program Components

A-1 Screening and Assessment[2]

Prenatal Screening

Prenatal health status can be an important predictor for health throughout a person's life. Screening can identify risk factors and/or excessive stresses that may negatively affect the mother's health, and the health of her baby. Research shows that women with identified risk factors benefit the most from MCH supports, often experiencing improved health and well-being before and after the birth of their baby.

Screening may be done to identify risk factors that may affect brain development in utero. It may also identify physical risk factors, such as sexually transmitted infections, HIV, Strep B, genetic problems or elevated blood glucose which can lead to gestational diabetes. Screening for physical risk factors should be done during early prenatal primary care visits. The MCH Program can play an important role in helping women access prenatal primary health care and educating them about potential health risks and the benefits of screening during pregnancy. This may

[2]Please see Screening and Assessment paper that complements this document.

encourage their participation in testing.

Once risk factors are identified, the MCH Program can provide women with the education, support and resources necessary to reduce high-risk behaviours and promote healthy, full-term births.

Screening from Birth to Age Six

Screening families in the community that have a baby or children under the age of six can identify risk factors and/or stresses that might negatively influence the health of the child and the rest of the family. For example, the Edinburgh postnatal depression scale may be used following birth to identify women at risk for developing postpartum depression (PPD). Women at risk for PPD may receive supports through the MCH Program to minimize the potential of developing depression. Another effective screening tool is the Nipissing Developmental Checklist, which helps parents identify potential developmental delays in their young children. If developmental concerns are evident, parents can seek help to address the potential problem early, and improve the developmental outcomes of their child.

There are many effective screening tools that communities can use to identify women and families who would benefit from the supports provided by the MCH Program. Tools may be broad and deal with many areas of well-being, or may consider only a single health behaviour such as the use of alcohol during pregnancy.

Although primary health care professionals and community service providers have an important role to play in the more formal screening process, individuals and family members can participate in informal screening. Expectant women and families with young children can be encouraged to seek out the services provided through the program and to learn more about pregnancy and child health. They may also participate by learning about risk factors during pregnancy and healthy child development, which includes age-appropriate expectations of their children and monitoring their own child's development.

Assessment

The goal of assessment is to establish an effective provider–family relationship based on mutual respect and trust. A systematic process for understanding the stresses and risk factors within families is developed. An in-depth assessment is a comprehensive process of identifying family goals, issues and concerns, coping skills and problem-solving strategies, as well as the strengths and resources that may be drawn upon and included as part of the family plan.

In-depth assessments are holistic and include the physical, social, emotional, psychological and spiritual/cultural well-being of mothers and their families. They are generally completed by Community Health Nurses (CHN) who have extensive training and skills in assessment and are able to complete the assessment through observation, exploration and dialogue with the family. They are done in collaboration with the Family Visitor (FV) who brings a strong cultural

understanding to the interaction. In-depth assessment provides the framework for home visiting and service coordination activities. It is usually done at the time of the initial referral or early in the relationship with the providers.

A-2) Home Visiting

An important component of the MCH Program is home visiting by CHNs and FVs. Evidence shows that home visiting improves maternal, child and family health outcomes. Because the experience, knowledge, skills and roles of the CHN and FV are complementary, families benefit from the unique support that they provide through blended home visiting. While the benefits are clear, it is essential that home visiting be provided by the right people, with the appropriate background, training and skills.

The primary reason for home visiting is to reach families at risk of poor health outcomes and overcome barriers that prevent access to services and supports. Home visits are particularly important for families with many problems who may be suspicious or reluctant to work with health care professionals or to attend a clinic setting. Home visiting increases the comfort level of families. If the home visitors are from outside the community, they receive training to ensure that they are sensitive to First Nations cultural beliefs, values and health practices. Working with a home visitor is often the first step in helping isolated families to reconnect in a meaningful way with their community.

Positive health outcomes of home visits include:

- improvement in infant and child cognitive development and physical growth;
- reduction in mothers' anxiety;
- less depression;
- more maternal employment;
- improved nutrition;
- positive lifestyle changes (e.g. reduced tobacco and alcohol use during pregnancy);
- improved reproductive health for women;
- improved parenting and child care behaviours;
- reduction in abuse and neglect; and
- decreased costs to the health care system.

Additional positive effects have been observed on social health, parental knowledge and use of other services. These effects include the level of parental involvement, responsiveness to a child's cues and behaviour, quantity and quality of parent–child interactions, quality of conversation, and a more positive attitude toward the child. There have been reported decreases in relationship difficulties and negative interactions. Home visiting has positive associations including more realistic expectations of children, more involvement of mothers in their children's school, and greater stimulation of children by parents to encourage achievement.

The degree of the positive effect achieved through home visiting is influenced by the intensity of the home visits and the level of health and social wellness of the family. Higher intensity of home

visiting is associated with greater health improvements. Home visits to families with more risk factors has a greater impact on their health than to clients who have fewer risk factors. When included as part of a broad range of services, home visiting improves outcomes with respect to child development, home environment, incidence of neglect and abuse, reduced low birthweight and more use of community-based services. Longer term effects of home visiting in the early years have been shown into the teen and early adult years with respect to getting and holding a job, reducing school dropout rates, reducing delinquency and crime, and reducing emotional problems.

Elements of Successful Home Visiting Programs

- **Qualifications of Home Visitors:** For home visiting programs to be successful, both professional (CHN) and peer (FV) home visiting must be provided, as this combination is the most effective. Although many of the positive impacts of home visiting have been attributed to professional nurse visits, FVs are able to gain insight into the families and communities in which they work; share their experiences, culture and life stories; and motivate parents to want to change. They can also relate to families on a personal level and understand the challenges they have to overcome. As caregivers themselves, FVs can offer practical support, role modelling and mentoring aimed at improving maternal confidence and strengthening parenting skills.

- **Timing of the Service:** Home visiting should begin during pregnancy. Continued long-term involvement, comprehensive and flexible services, and coordination of home visiting with other programs and services ensure that families do not miss out on supports.

- **Multi-Strategy Approach:** Home visiting should be linked to other services in the community as part of a plan of care that is individually tailored to the unique needs of each family.

- **Effective Elements of Home Visiting Programs for First Nations Families:** emphasize traditional cultural aspects of pregnancy and parenting, vary intensity of visiting depending on the family's needs, and establish mutually respectful and trusting relationships.

- **Comprehensive Training:** CHNs should receive training on clinical supervision, the scope and role of the FV and their own role in long term home visiting. They must establish clear lines of communication with the FVs and develop a process for clinical supervision. It is also crucial that FVs have intensive training on the scope of their role and boundaries, and education about healthy growth and development, parenting, community resources, and child and family health.

The Role of the CHN Related to Home Visiting

The CHN has two distinct roles as part of the MCH Program: home visiting support and clinical supervision of FVs.

Home Visiting Support: While the main role of the CHN will be to provide clinical supervision to the FVs, they will also provide home visiting support to First Nations families during pregnancy, after birth, and throughout the first six years of a child's life. The CHN works with the FV to address identified and potential health issues for families. The CHN also provides assessment, health education, supportive counselling and referrals to other appropriate services. The CHN and FV complete the initial in-depth assessment together. Periodic assessments throughout the family's involvement in the program ensure that the family's needs are being met and that the services the families access are coordinated as part of their family plan.

Home visits with the family, the CHN and the FV may be useful at times to review the family plan, clarify roles and address any other issues as they arise. Because the CHN provides the direct clinical supervision of the FV, it is important that the nurse know the families on the FV caseload well and is familiar with their strengths and needs.

Clinical Supervision of FVs: The CHN provides clinical supervision of the FV who visits in the home. "Clinical supervision" involves:

- maintaining a minimum of weekly contact (by phone, Web-based conferencing or in person) with FVs to review their role with families and consult on identified issues;
- reviewing FV documentation;
- assisting with problem solving as issues with the family arise;
- reviewing boundaries;
- discussing other services or supports that may be beneficial for the family;
- identifying knowledge gaps of the FV and linking with good sources of information and other resources;
- consulting on difficult circumstances, such as child protection concerns, concerns of safety or potential violence, and reinforcing policies, procedures and protocols developed for the program;
- sharing information that is important for service coordination, such as disclosure of substance abuse, physical violence, etc.; and
- following up on health issues identified by the FV that are beyond the scope of the FV's role or knowledge.

Core Competencies of the CHN

CHNs are Registered Nurses with specialized training in community and/or public health nursing. Core competencies include:

- individual and community assessment;
- individual and community empowerment;
- case management, service coordination and service planning;
- advocacy;
- effective problem solving and critical thinking;
- health teaching;

- group facilitation;
- physical assessment;
- clinical supervision and support for the FV;
- strong knowledge of maternal child health;
- skills in providing culturally competent and safe care;
- strong interpersonal and communication skills;
- an interdisciplinary team approach and effective collaboration; and
- ability to carry out program evaluation activities.

The Role of the FV

FVs are experienced mothers from the community with special training to be an FV. Many communities already have home visitors in other programs, such as AHSOR, who may receive additional training to take on the FV role. This may be a particularly effective approach in smaller communities. The FV role includes a focus on culture, role modelling, mentoring, health teaching and linking with community resources. The FV provides practical assistance with parenting and demonstrates skills such as basic infant care, infant stimulation, fostering healthy child development and self-care/coping as a parent. The FV offers a hands-on approach to learning and supportive mentoring as a peer. The frequency of home visiting by the FV is negotiated with the family. It is important, however, that the higher the level of identified need for the family, the more frequent the visits of the FV should be.

Frequent home visits early in the relationship allow the FV to establish an effective rapport with the family based on mutual respect and trust. It also allows the FV to get to know the family well and to have a good understanding of the family's goals for home visiting. The FV connects with the CHN weekly for clinical supervision.

Core Competencies of the FV

- personal experience as a parent/caregiver of infants and young children;
- desire to provide in-home support to families in their community;
- strong connections to and involvement in the community;
- able to relate to families;
- effective communication and interpersonal skills;
- able to role model effective parenting skills and positive parent–child interaction;
- non-judgmental approach and accepting of each family's uniqueness;
- effective problem-solving skills;
- able to work effectively, both independently and as a member of a team;
- able to take direction and follow recommendations;
- willing to complete required training and follow policies and procedures related to the FV role;
- strong knowledge of cultural beliefs and practices relating to pregnancy, birth and parenting; and
- role modelling and mentoring skills**.**

4.3 Activities of CHNs and FV during Home Visits

During prenatal visits	• Linking with Elders for traditional caring practices • Facilitating linkages with community supports • Encouraging mothers to access early, adequate prenatal health care • Reinforcing health teaching, such as signs of preterm labour and factors influencing a healthy pregnancy, including healthy nutrition, oral health and physical activity, as well as reducing use of alcohol, tobacco and other substances • Providing support and reassurance • Increasing social support from Elders and other community members • Assisting with preparation for the baby, such as identifying needs for infant supplies and equipment • Reinforcing cultural health practices and supports for the family • Encouraging mothers to breastfeed • Documenting the activities with the family • Doing appropriate follow-up when significant issues are identified • Getting ready for labour and delivery, preparing for a birth outside of the home community, and parenting a newborn • Strengthening coping skills and decreasing stress • Providing information on family violence
During postpartum visits	• Linking with Elders for traditional caring practices • Reinforcing health teaching, such as physical recovery, potential complications, reproductive health and family planning • Identifying and referring to intervention for postpartum depression • Providing peer support and encouragement for breastfeeding and referring to breastfeeding counselling if needed • Fostering parent–child bonding and infant attachment • Teaching on normal infant behaviour, crying and sleep • Reinforcing importance of caring for each other as well as infant • Providing support for transition to parenting and caring for newborn, including providing a safe environment in the home, the car and the community • Linking with community supports and resources • Encouraging the family to access primary health care • Reinforcing cultural health practices and supports for the family • Teaching about the prevention of SIDS • Doing appropriate follow-up when significant issues are identified • Reinforcing importance of primary care visits for mother and newborn

Birth to six years	• Providing information about age-appropriate developmental expectations • Screening for healthy growth and development using screening tools and referring for further assessment if needed • Encouraging parents to participate actively in monitoring their child's growth and development • Role modelling effective play and interaction with the child, reinforcing the importance of infant stimulation • Providing positive reinforcement for the parenting skills observed • Providing parenting support and education • Supporting family to access primary health care, such as immunization, etc. • Reinforcing cultural practices and supports for the family in the community • Providing information on caring for an infant and young child, including long-term breastfeeding, use of formula, transition to cow's milk, introduction of solids, oral health, sleep routines, crying and physical activity, as well as on a safe environment at home, in the car and in the community • Providing information on caring for self, including reproductive health, healthy relationships and reducing use of tobacco, alcohol and other substances • Teaching the family to care for their special needs child • Linking with community resources, such as AHSOR, BFI, CPNP and traditional supports including Elders • Identifying barriers to accessing supports and work with the CHN and the family to identify solutions • Following up appropriately when significant issues are identified • Returning to work or school and related supports

Service Coordination (Case Management)

Service coordination within the MCH Program is key to increasing access to services for families dealing with complex issues and/or special needs in children. The CHN and FV will work collaboratively with families to identify their needs. They will then develop a comprehensive plan of care that reflects all of the services and supports a family may choose to access. The plan of care for families should focus on their identified issues and use the strengths and resources of the family and the community. In addition, service coordination must include cultural traditions, practices and values which not only optimize infant health, but are considered crucial to women's adaptation throughout their child-bearing years. The use of culturally appropriate interventions can facilitate optimal health for mothers and their families and ensure that the needs of the family are met.

Once a plan of care is established and implemented for the family, regular communication between the family, the CHN, the FV and any other service providers involved is important. Communication will ensure that the plan of care effectively addresses the family's needs. Plans of care are flexible and should be revised as family needs change, issues resolve or new ones arise. When a family's needs are met and the plan of care is complete, the CHN, the FV, the family and other involved service providers determine together if services are no longer needed and establish a plan for the family to reconnect with services in the future if the need should arise. There is no time limitation for MCH services, so it is important that families do not stop receiving services

until they feel they are no longer needed.

Service Coordination (Case Management)

Service coordination activities include:

- completing the initial family assessment;
- identifying family strengths and assets;
- working with the family to identify and prioritize their needs and issues;
- working in partnership with the family, FV and other service providers to develop the family plan that reflects the family's goals and issues and the individual, family and community strengths that can be used;
- identifying the need for special needs services and helping the family to access services;
- facilitating referrals when necessary; and
- evaluating the plan of care frequently, making adjustments based on the family's needs and desired outcomes.

5. PROGRAM PLANNING AND IMPLEMENTATION

5.1 Phased-in Approach to MCH Program Implementation

In the first years of funding, the MCH Program will be implemented in identified communities within each Region to allow for sufficient funding to hire staff to support effective MCH programs. At the same time, other communities will be supported to increase their capacity to prepare multi-year work plans in subsequent years. More communities will develop multi-year work plans each year as funding increases. The national FNIHB Office will use program evaluation outcomes to expand the program so that more First Nations communities can offer an MCH program.

The FNIHB Regions will work with their Regional planning processes to determine which communities will be invited to develop multi-year MCH work plans in the first years of funding. They will also work with other communities to increase their capacity to develop a plan. Criteria for community readiness to develop multi-year MCH work plans could include:

- a history of successful implementation of health programs, including demonstrated accountability with funding and evaluation;
- demonstrated coordination of community-based programs, such as nursing, CPNP, H&CC, COHI, AHSOF, FASD, etc.;
- community recognition of the need for an MCH program;
- community demonstration of capacity to hire and retain staff, both professional and para professional workers; and
- existing staff with effective working relationships and the ability to work together with a common goal and understanding.

Each Regional planning process will identify criteria for identifying which communities will submit multi-year work plans for MCH in the early years of funding.

5.2 Description of FNIHB Roles and Responsibilities in Planning

National Office
National Office will work with Regional offices, as well as First Nations organizations to develop:

Program Guidelines: The program guidelines document provides the background information for the program, the essential program elements and frameworks for planning, implementation and evaluation.

Program Logic Model: The Program Logic Model is a brief summary of the MCH Program goals, objectives, interventions/strategies and outcomes. It may be useful for communities to use as a starting point for program planning and to inform the broader community about the MCH Program. The logic model provides the basic framework for program evaluation.

Communication Materials: Key messages on the MCH Program and the model of implementation will be developed and distributed to Regions. Additional communication strategies will be implemented as needed.

Evaluation: FNIHB will develop a comprehensive evaluation framework that is consistent with the Program Logic Model. Infrastructure, training, tools and processes required for participation in program evaluation and data collection will be identified and provided to Regions and communities.

Three types of evaluation strategies will be included. The first strategy is process evaluation. This will focus on the planning and implementation process and will identify what worked well for communities. It will also focus on the challenges and barriers that were met in the first five years and the strategies that communities used to overcome them. This information will be very helpful for communities that implement MCH programs in subsequent years because they will be able to learn from those that have already implemented the MCH Program. Secondly, information on program outputs will also be collected from the beginning of the program. Thirdly an outcome evaluation will record changes within the lives of families that result from participation in the program.

Screening and Assessment Tools: Screening and assessment is an important component of the MCH Program. The guidelines include principles of screening and assessment. Several tools are listed for consideration in the attached Screening and Assessment document. The MCH Program guidelines require screening and assessment to occur in each participating community, but it is the responsibility of the community to determine how this will be done.

Work Plan Templates: Work plan templates for communities are included in the appendices of the program guidelines for reference. Communities may use the templates or adapt them to meet

their own local needs. Work plans must reflect the process of planning, implementation and ongoing evaluation over a four-year period.

Training: Training requirements should reflect core competencies as provided in the program guidelines. FNIHB will work with Regions to ensure that training opportunities and materials are available for all staff working in the MCH Program. Please see separate training paper.

5.3 Regional Roles and Responsibilities in Planning

The Regional Office will work in collaboration with First Nations leaders, key stakeholders and provincial/territorial partners to establish an effective planning process and to support the implementation and evaluation of the MCH Program in local communities.

The Regional role includes:

Communication: Regions will be responsible for communicating with First Nations leaders, key stakeholders and communities about the MCH Program and the process for participation. Regions may also facilitate communication across communities on the progress of local MCH programs and opportunities for program expansion.

Regional MCH Program Planning Structure and Process: Each Region will establish its own planning process and determine the membership and structure of the planning workgroup. Membership will involve First Nations organizations/communities, provincial/territorial governments, health care providers, social service providers, other FNIHB community program representatives, child welfare, etc. Once the first-year communities are identified, it is recommended that they be represented on the workgroup as well.

Regions will need to involve provincial/territorial governments in planning the MCH Program on reserve because their health care systems will provide most obstetric and neonatal health care services during childbirth, care for ill newborns and young children with special needs.

Readiness Criteria: Each Region will use the federal readiness criteria as guidelines for developing their own criteria for selecting communities to participate in the first year of program funding. Community selection should be clear, transparent and based on Regional criteria. At the same time, regions will work with identified communities to increase their capacity to prepare MCH work plans in year 2 of the program and beyond.

Program Implementation: Regions play an important role in anticipating and supporting implementation needs at the community level. These include supporting the hiring and retention of new staff, providing training opportunities for CHNs and FVs, working with provincial/territorial health systems to develop and implement referral protocols for families living on reserve who are in need of or receiving tertiary health care, facilitating access to services for children with special needs, and exploring the potential for bringing safe birthing closer to communities.

Comprehensive Regional Work Plan: Regions will complete an MCH work plan that includes the details of how program components will be implemented at a Regional level. These include the:

- process to establish dialogue with provincial/territorial health care systems to explore strategies to bring safe birthing closer to communities;
- process to identify communities to develop multi-year MCH work plans in the first year of funding;
- number of communities identified;
- number of communities in each phase of the program development process, including a roll-up of the number of staff hired, number of families in the program, number of home visits provided, age of children in families receiving home visits;
- process to work effectively to increase the readiness of other communities to develop MCH program plans; and
- process to work with identified participating communities and help them to complete their multi-year work plans (e.g. provide mentoring for participating communities and practical support with problem solving/addressing system issues and barriers to effective MCH services).

5.4 Building Community Plans

Phases will be identified for the MCH Program from "start-up" to evaluation. Communities will be funded for each of these phases which will build toward putting a comprehensive program in place.

Shared Vision for the Health and Well-Being of Children Within Community

Each community that develops an MCH work plan should come to an agreement on its local vision for the health and well-being of mothers, infants and children within the community. This vision should be endorsed and supported by community leadership, the local planning committee and the broader community. The local vision must be consistent with the overall vision of the MCH Program and reflect the community's commitment to promoting and protecting maternal child health in all aspects of community life.

Steps for Community Planning

Each community will have its own unique approach to planning and putting the MCH Program in place, which is based on its experience, knowledge and unique community characteristics. However, the following steps may be useful to guide community planning and in setting up community planning frameworks.

Step 1: Identify the community MCH planning workgroup membership, and establish a planning team.

Workgroup membership may include individuals representing community leaders, primary care

providers, Elders, social service providers, traditional healers, traditional midwives, community health representatives, home and community care program, child welfare, Health Canada's community-based programs (BFI, BHC, AHSOR, CPNP, FASD, COHI, nursing, etc.), and families that may benefit from the program in the community. Each community must decide who needs to be involved with the planning and implementation process.

Step 2: Develop a community vision for MCH and share with community members.

Support and commitment from the community leadership will be an important factor in successful implementation of the MCH Program. Activities to raise awareness of the importance of maternal and child health within the community may be an important activity to strengthen the community's commitment to the program.

Step 3: Establish an effective relationship and process for communication with staff from the Regional FNIHB. The Regional Office will be an important partner in supporting the planning and implementation of the MCH Program.

Step 4: Take an inventory of asset mapping (community strengths) and needs assessments that have been completed in the community.

Identify information that is relevant to MCH and identify any gaps in information. Develop a process for completing the asset mapping and needs assessment process if it has not been done for the community before.

Step 5: Develop key tasks to be achieved, strategies, realistic timelines and outcomes.

Step 6: Document the community plan.

Key planning areas to consider are all activities and actions required to meet program goals and operational needs, including hiring, training and service coordination processes.

Step 7: Submit a detailed workplan to regions including projections of program expenditures.

Draw on information gathered from the program guidelines and the community needs assessment to determine where program resources need to be spent.

Step 8: Once approved by Regional FNIHB, initiate the workplan and participate in evaluation activities.

Participate in evaluation activities and data collection to document both process outcomes and health outcomes influenced by the MCH Program. Be flexible and adapt plans as needed to ensure that community needs are being met and resources are used in the best way possible

Needs Assessment

An early task of the community-level planning group will be to conduct a needs assessment for its community. A needs assessment is a process that a community, group or individual may do to evaluate the current state of a particular issue or area of concern and to identify actual or potential deficits, gaps in services, barriers to achieving the desired outcome, or opportunities to do things in a different way. When a needs assessment and asset mapping are done together, communities will have a complete picture of the issues that need to be addressed in the planning process and the strengths and resources ("assets"[3]) that can be mobilized. When developing MCH implementation plans, communities should examine their MCH programs, services and supports and identify perceived and actual barriers, gaps and limitations. Examples of barriers may include long wait lists, eligibility criteria, complex referral processes, lack of coordination within the community, lack of transportation or the location of services, and lack of cultural appropriateness. Gaps in services may be related to lack of funding, cost of services, cultural insensitivity, limited availability in terms of hours and locations, inadequate levels of support, lower priority within the community, or a lack of health professionals or appropriate service providers.

6. PROGRAM EVALUATION FRAMEWORK

*** Under development***

[3] For more information on asset mapping, please see Workplan Template

Annex A

Inequities of Health Status for First Nations Women and Young Children

Inequities of health status for First Nations women and young children include:

- infant mortality rates twice the Canadian rate. Causes of death are attributed to SIDS, congenital anomalies, respiratory problems, unintentional injury
- shorter gestations but higher incidence of high birthweight babies
- more likely to have had a preterm birth than other Canadian women
- higher rates of tuberculosis, hepatitis, gastroenteritis, meningitis and sexually transmitted infections
- higher rates of respiratory tract infections, including bronchitis, croup and pneumonia for infants and young children
- higher rates of severe otitis media causing significant hearing loss in at least one ear by age five
- very high prevalence of iron deficiency anaemia in infants and young children, and also higher prevalence of vitamin D deficiency
- higher gestational diabetes mellitus (GDM) rates for women and a significantly higher incidence of developing NIDDM following GDM. This is alarming as there is a correlation between diabetes in mothers and the development of diabetes in their children.
- higher rates of fetal alcohol spectrum disorder based on national statistics. Rate estimates of FASD should be 9.1/1000. FASD studies in British Columbia and Manitoba found rates of FASD in First Nations communities to be as high as 25–190/1,000.
- higher prevalence of dental health problems, including dental caries and missing teeth
- higher rates of morbidity and mortality from unintentional injuries than other children. First Nations children were 70% more likely than Canadian children to report one or more injuries in the previous year.
- over half (55.2%) of First Nations children on reserve overweight (22.3%) or obese (36.2%). First Nations children age three to five are more likely to be obese, at 48.7%.
- increases in new HIV/AIDS diagnoses which now comprise 10% of newly diagnosed cases where ethnicity is known
- gradual shift from high rates of infectious diseases in children to high rates of behaviour-related problems (highest rate in the 12+ age category).

Annex B

Health Canada's Community-based Programs

Aboriginal Diabetes Initiative	Aims to reduce the incidence and prevalence of diabetes by offering health promotion, prevention, treatment and lifestyle support services in community settings.
Aboriginal Head Start on Reserve (AHSOR)	Early intervention program which helps to promote optimal child development by addressing children's emotional, social, health, nutritional and psychological needs
Brighter Future Initiative	Provides access to holistic and community-directed mental health, child development and injury prevention services at the community level.
Building Healthy Communities Program – Mental Health Crisis Intervention (MHCI)	Mental health and crisis intervention program that includes assessments, counselling services, treatment and rehabilitation to individuals and communities in crisis.
Canada Prenatal Nutrition Program	Supports activities related to nutrition screening, education and counselling, maternal nourishment and breastfeeding promotion and support.
Children's Oral Health Initiative	Promotion of dental health and treatment for those in need.
Fetal Alcohol Spectrum Disorder Program (FASD)	Provides knowledge, tools and resources to build capacity, continue awareness activities started under the initiative and permit some communities to provide sustainable FASD prevention and intervention programming.
First Nations and Inuit Tobacco Control Strategy (FNITCS)	Supports the delivery of national and regional culturally appropriate education projects in an effort to increase knowledge about the harmful effects of tobacco use, and provide strategies for cessation.
Indian Residential Schools Mental Health Support Program	Provides access to mental health, transportation services and emotional support services for eligible claimants.
Injury Prevention	Supports the development and delivery of culturally appropriate activities that aim to raise awareness, change behaviours and create supportive environments to reduce the rate of injuries in First Nations and Inuit communities across Canada.
Medical Officer of Health	Provides professional advice on the public health aspects of community health programs related to First Nations populations. Advises FNIHB staff, service providers, community leaders on public health programs.

National Native Alcohol and Drug Abuse Program (NNADAP)	A national network of 50 treatment centres operated by First Nations organizations and/or communities that provide culturally appropriate in-patient and out-patient treatment services for alcohol and other forms of substance abuse.
Nursing Services	Provides primary health care (including public health) in all First Nations communities. Nurses provide prenatal/postpartum care in clinic and group settings.
Nutrition and Physical Activity Promotion	Supports the development and delivery of programs that focus on proper nutrition and appropriate levels of physical activity.
Youth Solvent Abuse Program (YSAP)	Prevention, intervention, after-care and in-patient treatment program that targets First Nations and Inuit youth who are addicted to or at risk of inhaling solvents.

Annex C

Screening Strategies Recommended During Pregnancy

Screening strategies the 2005 *Report on Maternal Child Health in Canada* recommended during pregnancy are:

- alcohol and drug use
- smoking or exposure to second-hand smoke
- nutritional status
- HIV
- group B strep
- sexually transmitted infections
- maternal serum screening
- blood glucose screening for gestational diabetes
- social/economic risk factors
- life stress

Recommended screening strategies from birth to age six are:

- risk factors at birth for mothers (complications of birth, risk for developing postpartum depression) and newborns (feeding difficulties, congenital anomalies, preterm birth or low/high birthweight)
- parenting capacity and family functioning (basic needs, family violence, inadequate supports)
- achievement of developmental milestones and risk for child abuse or neglect